GACHA

Governor's Advisory Council on HIV/AIDS

Post Office Box 47844
Olympia, Washington 98504-7844

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TO: Jack Jourden, MPH, Director, Infectious Disease and Reproductive Health
John Peppert, Manager, Office of Prevention and Education Services
Claudia Catastini, Counseling, Testing, and Referrals and Partner Services Coordinator
Craig McLaughlin, Executive Director, Board of Health

FROM: Jeffrey Schouten, MD, Chair, Governor's Advisory Council on HIV/AIDS, on behalf of the Executive Committee

SUBJECT: Board of Health Presentation, January 12, 2005

The Governor's Advisory Council on HIV/AIDS (GACHA) Executive Committee (EC) would like to thank Jack, John, Claudia and Craig for their presentation to the Board of Health (BOH) of their recommendations concerning the WAC rules for HIV testing, counseling, partner counseling and referral services (PCRS), and prevention for HIV positives, on January 12, 2005. Overall, the presentation was a balanced and fair summary of the collaborative process, and the three reports and recommendations that preceded the collaborative. However, we would like to point out a couple of areas that remain of concern to the GACHA EC based upon the recommendations and comments made at the BOH hearing, in response to the BOH question about which of the proposals are controversial, and in anticipation of the proposed written WAC changes.

Regarding HIV testing, it was noted that the proposed recommendation is to remove the separate consent requirement and explicitly allow for written or oral consent, with documentation. While it was noted that some groups had advocated to explicitly require written consent, it was not noted that GACHA and other community representatives have strongly argued to the importance of keeping the HIV consent separate. This ensures that there is a specific discussion around the consent explicitly for HIV testing. GACHA supports the expansion of HIV testing with separate, specific, written consent. The de-linkage of some of the pre and post-test counseling requirements from testing, as discussed below, will go a long way to realizing this goal. We do not believe that the specific consent is as much an obstacle as are the counseling requirements. Under the proposed recommendation, health care providers could just add HIV testing to the long list of items in the consent to care agreements that patients sign, without a clear discussion with the patient that they need not consent to an HIV test to engage in care or receive services.

Regarding pre and post-test counseling, the GACHA EC supports the move to de-link HIV testing from the extensive current pre and post-test counseling requirements. However, we do not support the proposal to modify the requirement, in pretest counseling to inform people about

the option of anonymous versus confidential testing, to require that information only "when appropriate." The WAC needs more specificity than such a vague statement. The BOH was not informed about the disagreement concerning this proposed changed. While it was noted that it might not be appropriate when an employee was consenting to an HIV test after an occupational exposure, it seems appropriate in most all other settings, which apply to the vast majority of HIV tests performed. GACHA has repeatedly expressed their dissatisfaction when the names reporting rules adopted required only that anonymous testing be "reasonably" available. This proposed change further weakens the provision of information and access to anonymous testing. Surveys have repeatedly shown that the public does not yet understand the critical differences between confidential and anonymous testing.

Regarding changes in the PCRS process, the GACHA EC has strong concerns about the removal of the requirement to destroy the PCRS records after the investigation is complete or 90 days, whichever is sooner. The request has been made during the collaborative process to clarify when PCRS should be performed, and who has the primary responsibility to initiate the process. So, is this an ongoing process over the life of an HIV-infected person, to monitor and inform their sexual partners, as some have advocated, or is this a process that occurs an the time of initial diagnosis. Does the diagnosing testing agency, the primary care provider, or the specialist to whom the patient may be referred for their HIV care have primary responsibility for initiating the PCRS process? Clarification of these concerns would help clarify when records would need to be kept past 90 days. Overlying this confusion is the concern over the retention of these records for later criminal investigations as was implied in one of the questions from the BOH. Here, there is not a clear separation from the WAC rules and the RCW concerning behaviors endangering public health (BEPH). Perhaps it would best to leave the 90-day destruction rule unchanged, until the current collaborative process drafting possible RCW changes to the statutes addressing BEPH is complete. Hopefully, that process may help clarify when the transition from public health to the criminal justice system should occur, and how the information voluntarily disclosed during PCRS may, or may not, be used in a subsequent criminal prosecution. Also, while it was noted that the 90-day destruction rule was initially drafted when concerns about the confidentiality of reporting records was higher, we think that there is still a great deal of concern about the retention of those records as they relate to possible future criminal prosecution and whether or not PCRS is a one-time or ongoing process. Thus, the GACHA EC recommends that the 90-day destruction rule be evaluated in the larger context of the BEPH statutes and not changed at this time.

Again, the GACHA EC thanks both the DOH and the BOH for their inclusiveness in this process over the past year and look forward to working with the BOH as the DOH proposes specific changes to the WAC in the near future. These comments reflect the views of the GACHA EC, and as soon as the proposed changes are available, the full GACHA will review them and send comments to the BOH.

cc: Thomas Locke, MD, MPH, Chair, Board of Health